

EXHIBIT A

From: Felicia Rosario <felicia.rosario@gmail.com>
Sent: Tuesday, November 4, 2014 1:48 PM
To: Lawrence Ray
Subject: TFP research

Transference Focused Psychotherapy

Detailed Description:

Borderline personality disorder represents a severe clinical condition that affects 1-2% of the community and is characterized by a pervasive instability of interpersonal relationships, self-image, and affects, as well as a marked impulsivity; up to 10% of the patients commit suicide.

Transference-Focused Psychotherapy (TFP) is one psychotherapeutic approach among five that have been manualized and evaluated in RCTs. So far, TFP has not been compared to a control condition which is a crucial step in the evaluation of the efficacy of a psychosocial intervention.

This study is an RCT that compares one year of outpatient TFP to treatment by experienced community psychotherapists for borderline personality disorder.

Transference-Focused [Psychotherapy](#) (TFP) is a psychodynamic treatment designed especially for patients with [borderline personality disorder](#) (BPD). A distinguishing feature of TFP in contrast to many other treatments for BPD is the belief in a psychological structure that underlies the specific symptoms a borderline individual suffers from. In other words, the focus of treatment is on a deep psychological make-up – a mind structured around a fundamental split that determines the patient’s way of experiencing self and others and the environment.

Since this internal split determines the nature of the patient’s perceptions, it leads to the chaotic interpersonal relations, impulsive self-destructive behaviors, and other symptoms of BPD. The internal split is based on a model of the mind in which early affectively-charged experiences are cumulatively internalized over time in the individual’s mind and become established in the individual’s psychological structure as “object relations dyads” – units which combine a specific representation of the self and a specific representation of the other linked by a specific affect.

Different dyads represent different images of the self and of the other connected by different affects. These dyads are not exact, accurate representations of historical reality, but tend to represent extreme images and affects. In the course of psychological development, these separate dyads become integrated into a unified whole with a more mature and flexible sense of self and others in the world. However, in borderline individuals, these separate dyads do not become integrated in this way. Instead, dyads associated with sharply different affects exist independently from one another and determine the lack of continuity of the borderline patient’s subjective experience in life.

An obvious question is why this integration does not take place in individuals with BPD. TFP posits a multifactorial explanation in which elements of biologically-determined temperament and of environment combine to maintain this split psychological structure. In over-simplified terms, internal representations of

frustrating others in relation to a helpless deprived self are totally split off from internal representations of gratifying others in relation to a satisfied self.

These opposite images are imbued with intense affects, both hateful (in association with the first internal representation), and loving (in association with the second). While the patient has no conscious awareness of this split internal world (and his or her ability to identify with either side of it at different moments in time), this structure underlies and determines the symptoms mentioned above, such as chaos in interpersonal relations, emotional lability, black-and-white thinking, anger, and proneness to lapses in reality testing. In psychodynamic terms, this split internal structure corresponds to the syndrome of identity diffusion and use of primitive defense mechanisms. In more phenomenological terms, this psychological structure results in an individual going through life with a subjective experience that is fragmented, discontinuous, rigid and impoverished.

The treatment focuses on the transference — the patient's moment-to-moment experience of the therapist. It is believed that the patient lives out his/her predominant object relations dyads in the transference. Once the treatment frame is in place, the core task in TFP is to identify these internal object relations dyads that act as the “lenses” which determine the patient's experience of the self and the world. It is believed that the information that unfolds within the patient's relation with the therapist provides the most direct access to understanding the make-up of the patient's internal world for two reasons. First, it has immediacy and is observable by both therapist and patient simultaneously so that differing perceptions of the shared reality can be discussed in the moment. Second, it includes the affect that accompanies the perceptions, in contrast to discussion of historical material that can have an intellectualized quality

This twice-per-week individual psychotherapy has been developed over a period of decades and is described in a treatment manual 1,2,3,4. Although it dates back many years, TFP combines many of the elements described in the recently published Guidelines for the Treatment of Borderline Personality issued by the American Psychiatric Association.

For example, more than in most psychoanalytically based therapies, TFP places special emphasis on the assessment and on the treatment contract and frame 5. In fact, the method specifies that therapy itself cannot begin until these tasks are accomplished, until the conditions of treatment are in place. The setting up of the contract and frame has a behavioral quality in that parameters are established to deal with the likely threats both to the treatment and to the patient's [well-being](#) that may occur in the course of the treatment.

The patient is engaged as a collaborator in setting up these conditions. After the behavioral symptoms of borderline pathology are contained through structure and limit setting, the psychological structure that is believed to be the core of borderline personality is analyzed as it unfolds in the transference [the relation with the therapist as perceived by the patient]. Even with this emphasis on interpretation of the transference, TFP acknowledges the possible role of auxiliary treatments (e.g. for active eating disorders or substance abuse) and includes attention to pharmacological interventions to address specific symptoms.

The TFP manual describes the strategies, tactics, and techniques of treatment. In brief, as the unintegrated representations of self and other become delineated in the course of the treatment, the therapist helps the patient understand the reasons – the fears and anxieties – that support the continued separation of these fragmented senses of self and other. This understanding is accompanied by the experiencing of strong affects within the therapeutic relationship. The combination of understanding and affective experience can lead to the integration of the split-off representations and the creation of an integrated sense of the patient's identity and experience of others. This integrated psychological state translates into a decrease in affective lability, impulsivity and

interpersonal chaos, and the ability to proceed with effective choices in work and relationships. In other words, our experience is that the integration of the psychological structure can result in the resolution and cure of the borderline condition.

In his analyses of obsessional patients, Sigmund Freud suggested that they suffered from intrusive cognitions and compulsive activities. Early psychoanalysts delineated the phenomenology of obsessiveness, but did not differentiate what is currently termed obsessive-compulsive disorder from obsessional personality. However, it was widely recognized that the success of psychoanalysis with obsessional patients was limited due to rigid characterological defences and transference resistances. The present paper examines the case of a middle-aged obsessional academic who had been treated for nearly twenty years in a 'classical' Freudian psychoanalysis prior to entering Jungian analysis. It examines how persistent focus on Oedipal conflicts undesirably reinforced the transference resistance in this obsessional man, and suggests that focusing instead on diminishing the harshness of the super-ego via the therapeutic alliance, and fostering faith in the salutary aspects of unconscious processing has led to salutary results in this case. The biblical book of Job is adopted as ancient instruction in how to address the scrupulosity and addictive mental structuring of obsessiveness in analysis.

Transference-Focused Psychotherapy (TFP)

Our approach to personality disorder treatment and research is based on the understanding of personality disorders in general and BPD in specific that is described in another section of this website ([link to that section](#)). Transference-Focused Psychotherapy is grounded in contemporary psychoanalytic theory since we believe that psychoanalytic thinking has much to offer in terms of understanding and treating personality disorders. However, our approach includes specific modifications of technique to address the therapeutic needs of patients with borderline and other personality disorders. Our patients do not lie on the couch, do not come to see us four or five times per week, and we, the therapists, are far from silent and removed from the process. Two beliefs that inform our work, that we share with most other psychoanalysts, and that distinguish our work from that of say, a cognitive-behavioral therapy (for example, Dialectical Behavior Therapy [DBT], another treatment for BPD) are that:

"Symptoms," the observable, behavioral manifestations of any disorder, are explained significantly by internal, mental or emotional factors, not generally visible to the naked eye, and that attention to these internal emotional factors or states is an essential part of the treatment process; and

Over the course of a psychotherapy, some of the emotional factors that influence the problematic behaviors or symptoms and that had previously been unclear to the patient and therapist become clear to both through their mutual, careful attention to the goings on in the treatment relationship, which includes the *transference of images within the patient's mind, which they may not be fully aware of, to the person of the therapist (and others in their life)*. So with this overview, let us now proceed to build on our understanding of personality disorders to explain how we conceptualize treatment.

Within the *International Society for Transference-Focused Psychotherapy*, one of the more challenging aspects of our work, as therapists specializing in the treatment of personality disorders, is the process of sharing with patients our impression of their diagnosis, and outlining for them the type of treatment we are proposing. Albeit difficult, this process is an essential, and legally required aspect of the process of starting treatment, called "informed consent." Generally, we start with an explanation of the term: *Personality disorder*, as a term, may

sound negative and judgmental and it is important to have a clear understanding with our patients of the meaning of the term. We explain that there is a group of disorders that are thought to be long-term and enduring, in contrast to episodic, personality styles that at their core are defined by difficulties in the person's subjective, internal sense of *identity*, and chronic difficulties in his or her *interpersonal relationships*.

We explain that, while the world is enriched by the variety of personality styles that exist, when a person personifies and lives out a particular personality style in an extreme and inflexible way that causes a certain level of distress in one's emotional and interpersonal life, they meet criteria for a personality disorder. We find it helpful to give an overview of BPD as a disorder comprising difficulties in four areas: 1) **emotions** tend to be intense and rapidly shifting; 2) **relationships** tend to be conflicted and stormy; 3) there may be impulsive, self-destructive or self-defeating **behaviors**; and 4) there is a **lack of a clear and coherent sense of identity** (this last problem may underlie all the preceding ones). We also, in reviewing the particular symptoms of BPD that we have noted in the diagnostic phase we have just completed with the patient, note that there are different sub-types of BPD patients, each with different sets of primary or most-problematic features. Some may be more *impulsive* and overtly *inappropriately angry*, whereas others may be more "under the radar," characterized more prominently by the sense of *emptiness*, *fears of abandonment*, *suicidal feelings*, and more subtle shifts in their experience of others, from *idealizing* others to more quietly feeling *devaluing* or contemptuous of them. So with each patient we explain our understanding of his or her BPD symptoms and we inquire as to whether this understanding makes sense to the patient.

With this understanding of [personality disorders and BPD](#) described in another section of this website, our treatment model, Transference-focused Psychotherapy (TFP), logically follows. This twice-per-week individual psychotherapy combines many of the elements described in the Guidelines for the Treatment of Borderline Personality issued by the American Psychiatric Association with a deep understanding of mental processes. TFP has demonstrated efficacy across two randomized clinical trials to date in the treatment of the symptoms of BPD. In contrast to other models of treatment, models that tend to focus on reducing symptoms through behavioral control, skill-based teaching, and overt therapist support, coaching, and guidance, TFP has a very different mechanism of action. Although TFP, like other models, places special emphasis on patient assessment / evaluation, and on setting up a treatment contract (a mutually agreed upon set of conditions that serve as a framework for the work of the treatment), the emphasis in TFP is on helping patients understand the shifts in their experience of themselves, and in their experience of others, as this split sense of identity plays out through their experiences in work and relationships, and, importantly, as it plays out in the treatment relationship itself.

The work of TFP is roughly divided into an initial phase of establishing a structure for the treatment that includes limit-setting with respect to the patient's destructive behaviors and a longer phase of exploration of the patient's mind and sense of identity. In reality, the two phases overlap since there is observation and exploration from the beginning, and limit-setting may continue far into the treatment.

After confirming the patient's diagnosis, the therapist and patient work to identify factors in the patient's life that might interfere with the consistency and conduct of the treatment. Factors such as drug abuse or addiction, chronic misuse of medication, a severe eating disorder, and self-injury and suicidality - each of these factors constitute not only a threat to the patient's safety and well-being, but also to the treatment, and therefore, must be contained in order for the therapist and patient to do the work of TFP. Whereas some therapies work to provide concrete support in the moment that the patient is about to engage in one of these behaviors, TFP works differently. In TFP, we presume that the patient can largely take responsibility for these behaviors, at times with the help of adjunctive treatment such as Alcoholics Anonymous or an eating disorders support group, and in other cases simply through an agreement about how suicidality and self-injury are to be managed, with the understanding that the patient is in conflict about these urges and can try to stay with and strengthen the side that wants to refrain from the behavior.

As behavioral symptoms of personality disorder are contained through the discussion of and limit setting associated with the treatment contract, the psychological structure that is believed to be the core of the disorder is observed and understood as it unfolds in the transference, i.e., the relation with the therapist as perceived by the patient. The focus of treatment is on the patient's difficulties tolerating and integrating disparate images of the self and of others and on the misunderstandings that arise when the patient mistakenly sees aspects of his/her own feelings that are difficult to acknowledge as coming from the other person.

While we call our treatment Transference-Focused Psychotherapy because of the centrality of the exploration of the patient's experience of self and others through observation of the patient's experience of the therapy and the therapist, the treatment also focuses on the patient's difficulties in work and relationships outside the treatment. These areas are important in the exploration of the experience of self, others, and relation to the world. These areas are also where, along with improvement in the patient's sense of self, we will see the benefits of treatment. Nevertheless, the therapist's attention is ultimately directed to transference because we believe that observation of the patient's moment-to-moment experience of the therapist provides the most direct access to understanding the make-up of the patient's internal world. As the un-integrated representations of self and other get played out in the patient's life and in the treatment relationship itself - often accompanied by the intense experience of emotion - the therapist helps the patient contain the emotions and observe the representations and understand the reasons, the wishes, fears and anxieties that support the continued separation of these fragmented senses of self and other. The therapist also helps the patient to observe shifts in the dominant self experience, using therapeutic techniques that include 1) clarification of internal states, 2) confrontation of contradictions that are observed, and 3) interpretation that help explain the divisions and links between different states.

For example, when a meek and unassuming patient suddenly shifts into an overtly dissatisfied or hostile stance, the therapist might start by inquiring: "Have you noticed a shift in your feelings?" The therapist might continue: "Let's see if we can understand what you were experiencing in me as your feeling in the room shifted, and how the way you were experiencing yourself also shifted at that moment." Through this type of "detective" work (we sometimes use the image of the TV detective Colombo who calmly and quietly explored the evidence), we can begin to flesh out the patient's inner world of representations of self and other, to track the shift, usually a volatile and chaotic shift, between the patient's various self states, and ultimately help them to reach a more reflective stance about his or her emotional life – the fundamental goal of the treatment is to help the patient learn to *reflect* on emotional states that were previously not understood and were acted upon without reflection. The combination of understanding within the context of emotional experience can lead to the integration of the split-off representations and the creation of an integrated sense of the patient's identity and experience of others. This integrated psychological state translates into a decrease in emotional turbulence, impulsivity and interpersonal chaos, and the ability to proceed with effective choices in work and relationships. In other words, there is a positive cycle in which understanding of one's representational and emotional world leads to an increased ability to modulate emotions and, in turn, the enhanced modulation of emotions helps the patient further increase his or her capacity to reflect and understand.

Ultimately, our experience is that the integration of the initially fragmented psychological structure can result in the resolution of the personality disorder and help establish stable and deep relationships and commitments to work and other life activities.

By Barry Stern, PhD^[L]_{SEP} Frank Yeomans, MD, PhD

Transference focused therapy for [borderline personality disorder \(BPD\)](#) is a [psychotherapy](#) that focuses on using your relationship with your therapist to change how you relate to people in the world.

What is Transference?

Transference is the theoretical process by which emotions are transferred from one person to another. Transference is a key concept in [psychodynamic](#) psychotherapies. In these types of therapies, it is presumed that the patient's feelings about important people in his life (such as parents or caregivers) are transferred onto the therapist, so that he comes to feel about and reacts to the therapist as he would to these important figures in their lives. It is believed that through transference, the therapist can see how the individual interacts with people, and the therapist uses this information to help the individual build healthier relationships.

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Why is Transference Important in BPD?

Therapists who practice transference focused therapy for BPD believe that the key issues that cause the symptoms of BPD are related to dysfunctional relationships in childhood that continue to impact adolescent and adult relationship functioning. The theory is that through interactions with our caregivers in early childhood, we develop a sense of self, as well as mental representations of others. If something goes wrong during this development, we may have difficulty forming a solid sense of self, or have problems in how we relate to other people.

Because there is evidence that [childhood maltreatment](#) and/or early loss of caregivers is associated with increased risk of BPD, and because the [symptoms of BPD](#) include significant problems in relationships and instability in sense of self, some experts have proposed that BPD needs to be treated by building healthier relationships through the use of transference.

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Dialectical Behavior Therapy Individual and Group DBT

In transference focused therapy for BPD, the focus is on the interaction between the patient and the therapist. The therapist rarely gives advice or instructs you on what to do. Instead, the therapist will likely ask you many questions and help you explore your reactions during session.

In transference focused therapy, an emphasis is placed on the current moment (rather than the past). Instead of talking about how you related to your caregivers, you will spend more time talking about how you are relating to your therapist. The therapist also tends to remain neutral in this type of therapy (such as they will generally not give you their opinion), and is unavailable outside the therapy session (except in cases of emergencies).

Research Support for Transference Focused Therapy for BPD

Preliminary research supports the use of transference focused therapy for BPD. A randomized controlled study (the most stringent type of therapy study) demonstrated that transference focused therapy was equivalent to [dialectical behavior therapy \(DBT\)](#) in reducing some of the symptoms of BPD (suicidality), and was better than DBT in reducing additional symptoms (such as anger or impulsivity).

While this is promising preliminary support for the effectiveness of this treatment, it is important to note a major limitation of this study: Patients in the transference focused therapy condition received more individual psychotherapy than those in the DBT condition. So, while it is possible that transference focused therapy is as good if not better than DBT at reducing symptoms of BPD, it is also possible that the improvements were due to the patients receiving more therapy. More research is needed to examine the success of this treatment.

Transference-Focused Psychotherapy (TFP)

Transference-Focused Psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 1999) is a psychodynamic treatment based on Kernberg's (1984) modified ego-psychology and object relations theory of personality disorder. TFP was developed specifically for Borderline Personality Disorder (BPD) and an associated broader form of personality dysfunction classified as borderline personality organization. Kernberg (1984) considers

borderline personality organization to encompass other DSM personality disorders, since it is defined not by descriptive symptoms but rather by impairments in identity integration and defensive functioning.

Conceptual Model

According to this model, psychological representations of self and others – experienced at varying levels of consciousness – provide the foundation for thoughts, feelings, and behaviours. BPD is considered to consist of fragmented representations of self and others that are associated with strong affective experiences. These representations are conceptualized as having been influenced both by temperament and by difficult early attachment relationships – including traumatic experiences (See section on Traumatic Experiences on the BPD [Etiology](#) page)– and thus are difficult for patients to integrate within a stable sense of identity. Fragmented self and other (known as “object”) representations are thought to manifest in behaviours and in interpersonal relationships, often outside of the individual’s explicit awareness and frequently in contradictory ways. For example, helplessness and dependent behaviour may be experienced alongside defiant grandiosity and rejection of help.

The Treatment

TFP seeks to address the fragmented, often contradictory representations of self and others that contribute to fluctuating affects, problematic defense mechanisms, and unstable identity and relationships (Levy, Clarkin, Yeomans, et al., 2006). The therapy is highly structured, manualized, and involves an explicit treatment contract between therapist and patient. Therapy takes place twice per week in an individual format. The treatment contract clarifies the setting and conditions of the therapy, the roles of the participants, and the behaviours and issues to be addressed, including protocols for the handling of self-destructive behaviour (See section on [Suicidality and Self-Injury](#) in BPD). Containment of self-destructive behaviour is thus an early priority focus of interventions in TFP. As treatment progresses, the focus shifts to the major affect-laden themes that emerge in the relationship between the patient and the therapist (Caligor, Diamond, Yeomans, & Kernberg, 2009). Known as the transference, these relational patterns are thought to reflect inner representations. Although such representations are believed to stem from early childhood experience, the focus of interventions in TFP is primarily on their manifestation in the here-and-now of the transference. In contrast to ordinary relationships, in TFP problematic interpersonal patterns are allowed to emerge without typical social consequences, in order to foster exploration of their meaning in terms of inner representations and affects. Repeated clarification, confrontation, and interpretation of these patterns within a safe therapeutic relationship is considered to bring about changes in the patient’s psychological integration (Caligor et al., 2009; Levy, et al., 2006).

Research on TFP

Results from randomized controlled trials (RCTs) provide empirical support for the efficacy of TFP for BPD. In one such trial, conducted over three years, TFP served as the comparison condition for [schema-focused therapy](#) (SFT; Giesen-Bloo, van Dyck, Spinhoven, et al., 2006). TFP was found to be effective in reducing borderline symptomatology and improving quality of life, although not to the extent as in the SFT condition. Patients in the TFP condition had a significantly higher degree of suicidality at baseline than SFT patients, and there were some problems identified in the adherence of therapists to the TFP protocol.(Yeomans, 2007).

Another trial, conducted over one year by the developers of TFP (Clarkin, Levy, Lenzenweger, & Kernberg, 2007), compared TFP with [Dialectical Behaviour Therapy \(DBT\)](#) and supportive-psychotherapy (SFT; See section on [Other Dynamic Therapies](#) for BPD), with each therapy delivered by acknowledged experts in each model. Positive changes were seen for patients in each condition, with generally equivalent improvement in social and global functioning. TFP produced changes across a broader range of outcome measures than the

other two treatments. TFP and DBT reduced [suicidality](#) to the same extent. Importantly, only TFP was found to produce positive changes in attachment organization – an increase in secure attachment – and in reflective functioning, an indicator of the ability to contemplate one's own and other's mental states (Levy, Meehan, Kelly et al., 2006).

Doering and colleagues (2010) also investigated TFP in a randomized trial, comparing it with treatment by community psychotherapists over a one-year period. TFP was found to be superior in reducing impairment across several domains such as suicide attempts, treatment drop-out, borderline symptoms, and personality organization. However, self-injury was not significantly reduced by either TFP or the comparison treatment after one year.

The above-mentioned studies demonstrate the effectiveness of TFP as a specific treatment, and add further empirical support for the role of psychodynamic psychotherapy in the treatment of BPD. Psychodynamic psychotherapy generally aims for recovery as reflected by changes in personality organization, in addition to behavioural outcomes. Such changes are thought to contribute to overall functional improvements, and to protect against future relapse. The discovery that TFP, involving a focus on object relations and transference interpretation, produces inner changes (i.e., attachment style and reflectivity) is thus particularly encouraging. Future research is required to replicate and extend this finding, and to examine the hypothesized mechanisms of action in transference-focused psychotherapy.

Transference Focused Psychotherapy (TFP) Continued

Simone Hoermann, Ph.D., Corinne E. Zupanick, Psy.D. & Mark Dombeck, Ph.D.

In transference-focused psychotherapy (TFP) the agent of change is the relationship that forms between the therapist and the therapy participant. In other words, the relationship itself provides the means to identify and correct the faulty personality structure. This is achieved by providing the participant an updated map, or corrected template of relationships. This correction becomes possible through a process called "transference." In its simplest form, transference means the therapy participant experiences and expresses feelings toward the therapist that actually stem from other earlier relationships. This occurs because the therapy participant draws upon their old relationship template or map, formed during childhood, in order to understand and navigate the new relationship with their therapist. As transference occurs during therapy sessions, the therapist uses this experience as the tool to identify, to understand, and to update these internal representations (that were formed in the past). When TFP therapists notice this transference, they assist the recovering person to understand and to modify these internal representations.

The primary goal of TFP is to assist the therapy participant to receive a corrective emotional experience via the therapeutic relationship. The therapist seeks to create an empathic and soothing relational climate that enables the participant to directly experience painful, contradictory, and ambivalent feelings toward the therapist. In this safe and comforting setting, the therapy participant learns to confront and tolerate the disturbing feelings that emerge when the chaotic and split-off, self-object representations are activated. This ability to tolerate these highly uncomfortable feelings was simply not possible as an infant or child. The purpose of this process is to assist the recovering person to integrate split-off representations of self-and-other into a cohesive whole.

Now let's use an example to illustrate how this process works. Suppose a therapist is late to a therapy session. The previously idealized "all good" therapist representation will suddenly be replaced with its polar opposite "all bad" representation. This is because the therapy participant cannot hold these two opposite representations of the therapist simultaneously without experiencing a tremendous amount of distress. Nonetheless, the therapist would guide and support the therapy participant to call forth and experience both representations of the therapist simultaneously in order to permit an opportunity for integration, even in the midst of highly distressing feelings brought about by two split-off, opposite feelings toward the same object (the therapist). Overtime, the therapy participant learns they are able to briefly tolerate these feelings as they re-assemble a new, integrated, and single cohesive object representing the therapist. The therapy participant now has a new more accurate model of relationships that can then be applied to other relationships as well.

TFP differs from the traditional psychoanalytic technique of free-association, in several important ways. First, there is a very specific agenda. At the beginning of treatment, there is an extensive evaluation phase. Based on this evaluation, the therapist makes a diagnosis. The therapist and prospective participant discuss the diagnosis and agree upon a treatment contract together. Frequently, the person requesting therapy may have had previous, failed attempts at therapy. In this case, the reasons for earlier treatments failures are discussed. If there were any behaviors on part of the participant that were detrimental to the effectiveness of previous therapies (e.g., missing sessions, dishonesty, or not following treatment recommendations) those behaviors are addressed in the treatment contract. The therapy contract also addresses the boundaries of the treatment, such as frequency and duration of sessions, phone calls, and emergency procedures.

Second, the therapist is not simply a passive listener. Instead, the therapist typically takes on a very active role in the therapy, asking pointed, clarifying questions, and challenging self-destructive or other negative behaviors.

Third, the focus is on the here-and-now, present-day relationships. Childhood fantasies and conflicts between the Id, Ego, and Super-Ego are irrelevant. Instead, the focus is to help the recovering person make connections between their present relationship with the therapist, and the current problems they experience with other relationships in their life.

The recovering person is strongly encouraged to build a meaningful and productive life for themselves outside of therapy. This may include finding a job, going to school, or engaging in volunteer work. Typically the therapist and participant meet twice a week. Sometimes group treatment is also recommended. Furthermore, if there is an issue that requires additional attention, for instance a substance abuse problem, a referral may be made to adjunctive services such as Alcoholics Anonymous or a drug and alcohol treatment facility. This ensures the therapy remains focused and directed toward relational problems in the here-and-now. There is growing evidence that TFP is a very effective treatment for severe personality disorders (Paris, 2008).

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Transference Focused Psychotherapy

Transference Focused Psychotherapy

for Borderline Patients

OTTO F. KERNBERG

What follows is a summary of the psychoanalytically based psychotherapy for borderline personality organization as developed and manualized by a team of psychoanalysts, psychoanalytic psychotherapists, and researchers at the Department of Psychiatry of the Cornell University Medical College. This manualized psychotherapy is the product of 20 years of work of our research team at the Department of Psychiatry and the Westchester Division of the New York Hospital-Cornell Medical Center on applying psychoanalytic theory to the particular treatment requirements of patients with the severe personality disorders that we have called borderline personality organization

(Kernberg et al., 1989). These disorders include a large majority of the corresponding personality disorders described in DSM-IV, particularly the borderline, the schizoid, the schizotypal, the paranoid, the histrionic, the narcissistic, the antisocial, and the dependent personality disorders. Also included in this group are several other personality disorders not mentioned specifically in DSM-IV, such as the hypomanic and sado-masochistic personality disorders, hypochondriasis, and the syndrome of malignant

narcissism (Kernberg, 1996). Figure 1 reproduces the classification of personality disorders reflecting our approach, which combines categorical and dimensional criteria for relating the personality disorders to each other. All the disorders included in the borderline personality organization are circumscribed by a double fragmented line.

Descriptive and Psychostructural Characteristics

Borderline Personality Organization is characterized by psychostructural

characteristics that include: (a) the syndrome of identity diffusion, (b) the predominance of primitive defensive mechanisms centering around splitting, and (c) maintenance of reality testing. In contrast, less severe personality disorders, which we have called neurotic personality organization, particularly the hysterical, the obsessive compulsive, and the depressive masochistic personality disorders (shown in the upper region of Figure 1)

are characterized by psychostructural conditions that include: (a) solid ego identity, (b) the predominance of defensive operations centering around repression, and (c) excellent reality testing, including a differentiated sense of social tact and sensitivity (Sternberg, 1984).

The syndrome of identity diffusion is characterized by lack of integration of both the concept of self and the concept of significant others. Identity diffusion can be evaluated in mental status examinations by exploring the patient's self experience, the cross sectional and longitudinal integration or lack of integration of the self concept, and the integration or lack of integration of his concept of the most important others in his life. Lack of integration of the concepts of self and of significant others becomes evident

in nonreflective, contradictory or chaotic descriptions of self and others, and a lack of capacity to integrate or even to become aware of these contradictions. The primitive defensive operations include, first of all, the mechanism of splitting or primitive disassociation, characterized by a total emotional disconnection between contradictory ego states, particularly those associated with experiences of idealized and persecutory perceptions of the relationships with significant others. Splitting mechanisms are reinforced and complemented by primitive idealization and devaluation, omnipotence, omnipotent control, denial, and projective identification. The latter is a

primitive form of projection, in which empathy is maintained with what is projected, while unconscious tendencies are enacted to induce in the other what is being projected, and to attempt to control the other, who is

now assumed to function under the dominance of the projected aspect of the self experience. The predominance of primitive defensive operations is manifest in behavioral characteristics that tend to distort the patient/therapist interaction from the beginning. In contrast, the defensive operations

characteristic of neurotic personality organization, centering around repression, are not expressed in behaviors that significantly distort the patient's interpersonal interactions. They emerge only gradually in the course of the psychodynamic psychotherapy as disruptions in the flow of the patient's communications. In the mental status examination, the relative lack of conspicuousness of the manifestations of repression contrasts with the striking distortions stemming from the operation of the primitive

defenses of the patient with borderline personality organization.

Both patients with borderline and with neurotic personality organization present good reality testing, that is, the capacity to identify fully with ordinary social criteria of reality as presented to them in tactful confrontations. But at the neurotic level of personality organization, patients show a sense of tactfulness, empathy, discretion and self reflectiveness that contrasts with the unreasonable, impulsive, chaotic, affectively

fluctuating behavior typical of patients with borderline personality organization, who tend to accept and rationalize such behavior rather easily.

In patients with borderline personality organization, the lack of normal identity integration translates into a lack of capacity for a mature empathy with others, and a lack of mature evaluation of other people, who are seen either as idealized, persecutory or devalued persons. These patients have great difficulty establishing and sustaining intimate relationships, selecting appropriate partners, assessing their own interests and commitments to work, profession, social life, ethical and aesthetic ideals. The reliance of

these patients upon primitive defenses not only contributes to the impairment of their social and vocational functioning, but also results in general manifestations of ego weakness, particularly a lack of impulse control, lack of anxiety tolerance, and limitations in their sublimatory endeavors.

Secondary problems derived from borderline personality organization frequently include severe behavioral disturbances: the development of chronic, characterological suicidal and parasuicidal behaviors; severe eating disturbances; proneness to drug and alcohol abuse and dependency, and antisocial behavior. The presence of antisocial behavior is particularly important because of its negative prognostic implications for all

psychotherapeutic approaches to the personality disorders, an overriding prognostic indicator matched in importance only by the absence of intense relations with significant others. The more severe the antisocial behavior, and the more isolated the patient over an extended period of time, the worse the prognosis. Conversely, severe personality disorders without antisocial features and with a history of sustained interpersonal relationships, however chaotic or disturbed they may be, have a good likelihood of benefiting from the psychodynamic psychotherapy to be described. The single fragmented horizontal line in Figure 1 separates less severe (above this line) from more severe (below this line) personality disorders within borderline personality organization. The less severe group evinces a greater capacity for dependent relationships with significant others, more capacity for investing in work and social relations, and less of the non-specific manifestations of ego weakness referred to above.

Etiology and Psychopathology

Research findings have pointed to the prevalence, among patients with borderline pathology, of early traumatic experiences, such as prolonged, painful physical illness, experience or witnessing of physical or sexual abuse, severe early loss and abandonment, or a chaotic family structure (Kernberg, 1994). A biological predisposition

to the activation of excessive aggressive and depressive affects as a consequence of dysfunctional biochemical neurotransmitter systems, particularly the serotonergic system (but also the adrenergic, noradrenergic, and dopamenergic systems)

may be reflected in abnormal activation of negative affects, and hyperreactivity to stimuli that would ordinarily generate anxiety or depression, thus fostering the distortion of early affective experiences in the direction of aggressively invested relations with significant others that are internalized as such. Thus, biological determinants in the predisposition to negative affect activation reflected in temperament, and the internalization of significant relations with others dominated by aggression may eventually influence the concept of self and of others (Depue, 1996).

Under the impact of the etiological forces outlined above, the psychopathology of these patients emerges as dominated by aggressively invested internalized object relations. These threaten their libidinally invested internalized object relations, and determine a protective fixation and exaggeration of the early defensive operations of splitting and related mechanisms described before. Splitting mechanisms protect idealized representations of self and objects against their contamination with the

aggressive ones, and sustain, therefore, a certain hope for internal well being, safety and gratifying relations with others under conditions in which the dominance of aggressively invested internalized object relations threaten these patients with massive and pervasive distrust of others, with fear of the eruption of violent aggressive behavior from within or from others, and with the confusing distortions of a world view derived from the lack of

integration of the concept of self and others.

The development of stable characterological patterns that reflect such early learning experiences under conditions that foster excessive splitting leads to the consolidation of the syndrome of identity diffusion and the dominance of the primitive defenses mentioned. Additional etiological factors, particularly, predominant tendencies towards introversion or extroversion, and the extent to which a constitutional disposition to excessive activation of depressive or euphoric affects is present may codetermine the various characterological constellations under which the basic syndrome of identity diffusion emerges in clinical practice. The temperamentally determined tendency toward

extroversion characterizes the personality disorders on the right side of Figure 1, and the corresponding temperamental disposition toward introversion, on the left side of this classification of personality disorders.

The classification of personality disorders proposed here combines a structural and developmental concept of the psychic apparatus based upon a theory of internalized object relations, that permits classifying personality disorders according to the severity of the pathology, the extent to which the pathology is dominated by aggression, the extent to which pathological affective dispositions influence personality development, the effect of the development of a pathological grandiose self structure, and the potential

influence of a temperamental disposition to extroversion/introversion. In a combined analysis of the vicissitudes of instinctual conflicts between love and aggression, and of the development of ego and superego structures, it permits us to differentiate the various pathological personalities as well as to relate them to each other.

This classification also illuminates the advantages of combining categorical and dimensional criteria. There are clearly developmental factors relating several personality disorders to each other, particularly along an axis of severity. Figure 1 summarizes the relationships among the various personality disorders outlined in what follows. Thus, a developmental line links the borderline, the hypomanic, the cyclothymic, and the depressive-masochistic personality disorders. Another developmental line links the

borderline, the histrionic or infantile, the dependent, and the hysterical personality disorders. Still another developmental line links, in complex ways, the schizoid, schizotypal, paranoid, and hypochondriacal personality disorders, and, at a higher developmental level the obsessive-compulsive personality disorder. And finally, a developmental line links the antisocial personality, the malignant narcissism syndrome, and the narcissistic personality disorder (the latter, in turn, containing a broad spectrum

of severity). Further relationships of all prevalent personality disorders are indicated on

Figure 1.

In my view, the vicissitudes of internalized object relations and of the development of affective responses emerge as basic components of a contemporary psychoanalytic approach to the personality disorders. I have proposed elsewhere (1992) the concept of drives as supraordinate integration of the corresponding series of aggressive and libidinal affects, and applied it to an overall developmental and psychostructural model.

At the same time, the developmental vicissitudes of internalized object relations permit us to deepen our understanding of these patients' affective responses.

Affects always include a cognitive component, a subjective experience of a highly pleasurable or unpleasurable nature, neurovegetative discharge phenomena, psychomotor activation, and, very crucially, a distinctive pattern of facial expression that originally served a communicative function directed to the caregiver. The cognitive aspect of affective responses always reflects the relationship between a self representation and an object representation, which facilitates the diagnosis of the activated object relationship in each affect state that emerges in the therapeutic

relationship.

This classification also helps to clarify the vicissitudes of the development of the sexual and aggressive drives. From the initial response of rage as a basic affect develops the structured affect of hatred as the central affect state in severe personality disorders. Hatred, in turn, may take the form of conscious or unconscious envy, or an inordinate need for revenge that will color the corresponding transference developments. Similarly, regarding the sexual response, the psychoanalytic understanding of the internalized object relations activated in sexual fantasy and experience facilitates the diagnosis and treatment of abnormal condensations of sexual excitement and hatred such as in the perversions or paraphilias, and the inhibitions of sexuality and restrictions in the sexual responsiveness derived from its absorption in the patient's conflicts around internalized object relations.

The unconscious identification of the patient with the roles of both victim and

victimizer in cases of severe trauma and abuse can also be better diagnosed, understood, and worked through in the transference and countertransference in the light of the theory of internalized object relations that underlies this classification; and the understanding of the structural determinants of pathological narcissism permits resolution of the apparent

incapacity of narcissistic patients to develop differentiated transference reactions, in parallel to their severe distortions of object relations in general.

One crucial advantage of the proposed classification of personality disorders is that the underlying structural concepts permit the therapist to translate the patient's affect states into the object relationship being activated in the transference, and to "read" this transference in terms of the activation of a relationship that typically alternates in the projection of self and object representations. The more severe the patient's pathology, the more readily does the patient project either his self representation or his object

representation onto the therapist, while enacting the reciprocal object or self

representation. This makes it possible to clarify, in the midst of intense affect activation, the nature of the relationship, and to integrate the patient's previously split off representations of self and significant others by gradual interpretation of these developments in the transference. This conceptualization, therefore, has direct implications for the therapeutic approach to personality disorders (Kernberg et al.,

1989).

Therapeutic Strategy

From a therapeutic perspective, the main objective of the psychodynamic

psychotherapy to be described is to focus upon the syndrome of identity diffusion, its expression in the form of the activation of primitive object relations in the transference, and the exploration of these primitive transferences as they reflect early internalized object relations of an idealized and persecutory kind. The goal of this strategy is to identify such primitive transference paradigms and then to facilitate their gradual integration, so that splitting and other primitive defensive operations are replaced by more mature defensive operations, and identity diffusion is eventually resolved (Kernberg, 1984). The essential strategy takes place in three consecutive steps: (1) The dominant primitive object relation is identified in the transference, and is described in an appropriate metaphorical statement that includes a hypothesized relation between two people linked by a dominant peak affective state. (2) Within this dominant relationship, the patient's representation of self relating to the representation of a significant other ("object representation"), is described, and the patient is shown how that self representation, linked to its corresponding object representation by a specific affect, is activated with frequent role reversals in the transference. These role reversals show themselves in the patient's alternatively enacting his representation of self or of the corresponding object, while projecting the other member of the internalized object relationship into the therapist. In this second phase the patient learns not only to understand the different ways in which the same transference disposition may show in

completely contradictory behaviors, but to gradually tolerate his identification with both self and object representations in this interaction. (3) The idealized internalized object relations are interpretively integrated with their corresponding, opposite, split off persecutory ones, so that the patient, who already has learned to accept his identification with contradictory internalized representations of self and object at different points of

his treatment experience, now learns to integrate them, to accept that he harbors both loving and hateful feelings toward the same object, that his self concept is both "good" and "bad," and that his objects are neither as exclusively good or bad as he originally perceived them.

This gradual integration of the internal world of object relations leads towards the tolerance of ambivalence, a toning down and maturing of all affective experiences and emotional relations with significant others, a decrease in impulsive behaviors, and a growing capacity for self reflection and empathy with significant others as the patient's self concept consolidates in an integrated view of himself, and he or she experiences the

relationships with significant others in a new, integrated way. The objective of this psychodynamic psychotherapy, in summary, is the resolution of identity diffusion and of primitive defensive mechanisms. In practice, this

development shows up in several successive steps: at first, in successfully treated cases, one may observe a significant decrease in impulsive behavior; later on, a toning down of the patient's contradictory and explosive affects; and, eventually, the integration of normal ego identity.

Therapeutic Techniques

The psychodynamic psychotherapy for borderline personality organization just outlined derives from psychoanalytic technique, using essential concepts and techniques derived from psychoanalysis, but modifying them in specific ways that make this treatment clearly different from psychoanalysis proper. In fact, one of the origins of this treatment was the failure of standard psychoanalysis to help many patients with severe

personality disorders, and the need to modify the psychoanalytic treatment in the light of that experience (captured particularly in the psychotherapy research project of the Menninger Foundation) (Kernberg et al., 1972). The essential techniques taken from psychoanalysis that, in their respective modification, characterize the technique of this psychodynamic psychotherapy, are: (1) interpretation, (2) transference analysis, and (3)

technical neutrality.

The *technique of interpretation* includes the *clarification* of the patient's subjective experience, the tactful *confrontation* of those aspects of the patient's nonverbal behavior that are dissociated or split off from his subjective experience, the *interpretation in the*

"here and now" of hypothesized unconscious meanings of the patient's total behavior and their implicit conflictual nature, and the *interpretation of a hypothesized origin in the patient's past* of that unconscious meaning in the here and now. In psychodynamic psychotherapy, clarification, confrontation and interpretation of unconscious meanings in the here and now predominate in the early stages, while emphasis on the linkage to the patient's unconscious past takes place only in advanced stages of the treatment. The initial avoidance of genetic interpretations protects the patient from confusion between present and past, and from defensive intellectualization.

Transference analysis refers to the clarification, and confrontation, and interpretation of unconscious, pathogenic internalized object relations from the past that are typically activated very early in the relationship with the therapist. In simplest terms, the transference reflects the distortion of the initial therapist/patient relationship by the emergence of an unconscious, fantasized relationship from the past that the patient unwittingly or unwillingly enacts in the present treatment situation. In psychoanalysis, a

systematic analysis of transference developments is an essential technical tool; in psychoanalytic psychotherapy, transference analysis is modified by an ongoing linking of the relationship of such transference activations in the therapy hours with the patient's pathological enactments outside the treatment situation, while pathological interactions outside the treatment situation are also immediately explored in terms of their corresponding transference implications. This modification of the technique of transference analysis protects the treatment from the splitting of treatment hours from

the patient's external life.

Technical neutrality refers to the therapist's not taking sides regarding the patient's unconscious conflicts, his helping the patient to understand these conflicts by maintaining a neutral position. The therapist, in his total emotional reaction to the patient, that is, his countertransference reaction, may experience powerful feelings and the temptation to react in specific ways in response to the patient's transference challenges. Utilizing his countertransference response to better understand the transference without reacting to it, the therapist interprets the meanings of the

transference from a position of concerned objectivity, which is the most important application of the therapist's position of technical neutrality.

In the psychodynamic psychotherapy of borderline patients, tendencies toward expression in action rather than through verbal communication -- that is, "acting out" -- may threaten the patient's life, other peoples' lives, the continuity of the treatment, or the frame of the psychotherapeutic sessions. The therapist may have to establish limits to the patient's behavior, both within and outside the sessions, and this implies a movement

away from technical neutrality. That is, the therapist takes the side of preserving life and safety when the patient's behavior places these in jeopardy. Interpretation of the transference conflict that has motivated such abandonment of technical neutrality, interpretation of the patient's interpretation of the therapist's intervention, and the gradual reinstatement of technical neutrality as a consequence of such interpretations is

an essential sequence, often performed repeatedly in psychodynamic psychotherapy, differentiating it from psychoanalysis where technical neutrality can be maintained in a much more stable and consistent way. In summary, clarification, confrontation and interpretation in the "here and now" are the essential techniques in the psychodynamic

psychotherapy of borderline patients that make possible the resolution of primitive internalized object relations in the transference referred to above.

The establishment of an overall therapeutic relationship that determines a realistic relationship between patient and therapist -- and which also permits the diagnosis of its distortion by means of transference activation -- is reflected by the *treatment setting* and the *therapeutic frame*. The treatment setting refers to the time, space and regularity of therapeutic sessions. The therapeutic frame refers to specific tasks assigned to patient and therapist, namely, free and full communication of the patient's subjective

experiences ("free association"), and a consistently attentive, respectful, concerned and objective exploration of the patient's communications and the total treatment situation on the part of the therapist. These arrangements differ from standard psychoanalysis in the frequency of sessions, (a minimum of two or three in the psychotherapy, in contrast to three to five in standard psychoanalysis); and in the physical positioning of face to

face interviews in psychodynamic psychotherapy, in contrast to the use of the couch in standard psychoanalysis. The establishment of the minimal (and, in most cases, sufficient) frequency of two sessions per week permits the simultaneous analysis of what is going on in the patient's external life as well as in the transference: less than two sessions per week tends to weaken the possibility of a full grasp of either external reality or the transference.

The more severe the personality disorder, the more the patient's pathological behavior patterns and transference enactments show up in nonverbal behavior; the face to face position permits a full observation of this behavior. In fact, the data base for the therapist's therapeutic interventions may be classified as originating from three "channels": channel 1, the patient's verbal communication of his subjective experience;

channel 2, the patient's nonverbal behavior, including his communicative style; channel 3, the countertransference. While in standard psychoanalytic treatment, most information derives from channel 1 (although channels 2 and 3 are important sources of information as well), in psychoanalytic psychotherapy more information stems from channels 2 and 3, that is, the patient's non-verbal behavior and the emotional responses of the therapist to it. The therapist's emotional response to the patient at times reflects

empathy with the patient's central subjective experience (concordant identification in the countertransference), and reflects at other times the therapist's identification with what the patient cannot tolerate in himself, and is

projecting onto the therapist (complementary identification in the countertransference). Both reactions, when the therapist is able to identify and observe them, serve as valuable sources of information.

Countertransference analysis is in fact an essential aspect of this psychotherapy. The countertransference, defined as the total emotional reaction of the therapist to the patient at any particular point in time needs to be explored fully by the therapist's selfreflective function, controlled in the therapist's firmly staying in role, and utilized as material to be integrated into the therapist's interpretive interventions. Thus, the therapist's "metabolism" of the countertransference as part of the total material of each

hour, rather than its communication to the patient, characterizes this psychotherapeutic approach.

The tendency to severe acting out of the transference characteristic of borderline patients has been mentioned already; in addition to its management by the modification of technical neutrality and limit setting in the hours mentioned before, the treatment begins with the setting up of a *treatment contract*, which includes not only the treatment setting and frame as mentioned before, but also specific, highly individualized conditions for the treatment that derive from life threatening and potentially treatment

threatening aspects of the patient's psychopathology. Particularly, the establishment of realistic controls and limit setting that protect the patient from suicidal behavior and other destructive or self destructive patterns of behavior are typical objectives of contract setting. The initial contract setting is a major aspect of the psychodynamic psychotherapy of borderline patients, and can constitute a formidable preventive against

the tendency to premature dropout of treatment typical for all psychotherapies of patients with borderline personality organization.

Tactical Approaches in Each Hour

The general strategy of treatment and the techniques mentioned before are

complemented by tactical approaches within each session that facilitate the strategic and general technical approach to transference analysis. These tactical aspects include the effort to establish, first of all, a joint view of reality with the patient, thus reinforcing reality testing before interpreting unconscious meanings in the patient's present behavior. The patient's relationship to the interpretation, his interpretation of the therapist's interpretations need to be clarified, as well as the extent to which his

experiences reflect fantasies or acquire, at times, delusional characteristics. Within each session, as already implied earlier, both positive and negative transference dispositions are analyzed; primitive defensive mechanisms activated as part of transference enactments are also interpreted; acting out is controlled; and the patient's capacity for self observation and reflection tested as part of each interpretive effort.

In general, the interpretive focus in each session is determined by what is

affectively dominant at any point. Affect dominance takes precedence over transference dominance, in the sense that transference analysis is not a unique, exclusive focus, and when extra-transferential issues are affectively dominant, they take priority.

Due to the severity of complicating symptoms that these patients frequently present, particularly destructive and self-destructive behaviors, suicidal and para-suicidal tendencies, eating disturbances, abuse of drugs and/or alcohol and antisocial behavior, a set of priorities of intervention has been established as another essential aspect of the psychodynamic psychotherapy of borderline patients (Kernberg, 1992; Kernberg et al.,

1989). This set of priorities protects the patient and the treatment from the effects of such complications, while highlighting the need for their interpretive resolution as part of transference analysis. In practice, the following priorities should override other affectively present material as the first focus of the therapist's attention. Whenever a sense of danger to the patient's life, other people's lives or the patient's physical integrity emerges in the session, that particular subject matter represents the highest priority for immediate therapeutic intervention; threatened interruptions of the

treatment constitute the second highest priority; the presence of severe distortions in verbal communications, particularly chronic deceptiveness (which is typical for patients with both antisocial behavior and severe paranoid tendencies) constitutes a third priority; severe acting out, both in and outside the sessions, is a fourth priority; and the development of severe narcissistic resistances a fifth priority. The analysis of narcissistic

resistances follows the general principles of psychoanalytically derived techniques of dealing with such narcissistic defenses in the transference. In essence, narcissistic defenses become specific transference resistances against an authentic dependency on the therapist, because such a dependency would threaten the narcissistic patient's

pathological, grandiose self, and expose him to the activation of underlying conflicts with unconscious aggression, particularly severe conflicts around envy that need to be elaborated in the transference.

The treatment also includes particular techniques to deal with severe paranoid regressions and the development of delusional and hallucinatory manifestations in the sessions, techniques that are specific contributions of this psychotherapeutic approach to the treatment of severe regressions in the transference in the case of all patients subjected to psychodynamic or psychoanalytic treatment. The analysis of "incompatible realities" (Kernberg, 1992) as part of the exploration of transference psychosis usually

makes it possible to resolve severe paranoid regressions in the transference and the shift into depressive transference developments.

A general classification of transferences into predominantly psychopathic, paranoid, and depressive transferences signals three degrees of severity of transference regressions. In patients with significant antisocial behavior and corresponding superego pathology psychopathic transferences are particularly likely to emerge. Their systematic interpretation tends to transform them into paranoid transferences, which, when successfully interpreted, give way to depressive transferences. The latter constitute the

more normal levels of development that characterize the advanced stages of the treatment, in which the patient is able to experience ambivalence, guilt and concern, acknowledge his own aggressive tendencies towards self and others, mourn lost opportunities, express wishes for reparation and sublimatory trends in general. At this stage, the patient is on his or her way to improvement. Excessively severe depressive transferences, however, clearly indicate pathological submission to unconscious guilt, and this may constitute a problem in advanced stages of the treatment. The general

principle applies that psychopathic transferences need to be resolved before paranoid ones, and paranoid ones before depressive ones: this principle reflects another aspect of the general strategy of transference interpretation.

As may be rightly concluded from all that has been said so far, transference analysis is a central aspect of this psychodynamic psychotherapy for borderline conditions. It implies the transformation of the patient's pathological expression of intolerable unconscious conflict between love and hate derived from pathogenic experiences in the past into conscious elaboration of these conflicts in the context of transference analysis.

The gradual transformation of pathological character patterns into an emotional experience and self reflection in the transference implies the therapist's active effort, throughout the entire treatment, to retranslate repetitive, pathological behaviors and acting out, on the one hand, and defensive somatizations, hypochondriacal reactions, and attacks on the patient's own body, on the other, into emotional developments in the

transference. In the course of this process, it will become unavoidable to face very primitive traumatic experiences from the past reactivated as traumatic transference episodes in which, unconsciously, the patient may express traumautophilic tendencies in an effort to repeat past traumas in order to overcome them. Primitive fears and fantasies regarding

murderous and sexual attacks, primitive hatred, efforts to deny all psychological reality in order to escape from psychic pain are the order of the day in the psychodynamic psychotherapy of these patients. Severely traumatized patients, whose past experience of physical abuse, sexual abuse, and/or witnessing such abuse has had significant

etiological influence on their present psychopathology -- particularly, a severe personality disorder with borderline, narcissistic, and/or antisocial features -- typically present the following constellation of internalized object relations (Kernberg, 1994). They evince the unconscious dominance of a hateful, paralyzed, panic ridden victim self representation relating to a hateful, overpowering, sadistic object representation, a perpetrator/persecutor object representation linked to the self representation by hatred and its objective of inducing pain, sadistic control, humiliation and destruction. This internalized object relation, that has transformed the primitive affect of rage into a characterologically anchored, chronic disposition of hatred is activated in the transference with alternating role distribution: the patient's identification, for periods of time, with his victim self while projecting the sadistic persecutor onto the therapist, will

be followed, rapidly, in equally extended periods of time, by the projection of his victimized self onto the therapist while the patient identifies himself, unconsciously, with the sadistic perpetrator. In our experience, only a systematic interpretation of the patient's unconscious identification with both victim and perpetrator may resolve this pathological constellation and lead to a gradual integration of dissociated or split-off self representation into the patient's normal self. The effects of the traumatic past reside in

the patient's internalized object relations; the key to its therapeutic resolution is coming to terms with this double identification.

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To explore and resolve such conflicts the therapist has to maintain a stable and steady treatment frame, and at times, may require ongoing supervision or consultation in case of the development of intense and chronic countertransference reactions. The very sheltered nature of the therapeutic situation fosters the patient's expression of his unconscious conflictual needs and conflicts in this relationship. When everything goes well, severe regression in the psychotherapeutic sessions goes hand in hand with

dramatic improvement in the patient's life, often to be observed from very early on in the treatment. If either no such intense enactments occur in the hours, or intense transference regression coincides with unremitting manifestations of these behavior patterns outside the hours as well, these are indications that the treatment is not going well, and, by the same token, provide alarm signals to explore and correct the therapeutic approach. Ongoing supervision and consultation usually may resolve

therapeutic statements, if and when such alarm signals are duly registered and taken into consideration.

A major question frequently raised is, what does it take to become a psychotherapist expert in this treatment? Our experience has been that psychiatric residents who have had a good background and general training in psychodynamic techniques are able in advanced stages of their training to carry out such treatments under supervision; we have similar experiences with post doctoral fellows in clinical psychology who also have had

a good background and training in psychodynamic psychotherapy and are under appropriate supervision. Undoubtedly, there are some residents and young graduates with more talents than others to carry out this treatment, and a parallel psychoanalytic training provides an in-depth knowledge and experience with psychodynamic concepts that enormously helps the talented psychotherapist to improve his technical approach. We need to stress that this treatment modality follows very naturally the lines of general psychodynamic psychotherapy, and as such is easier to be taught than the complexity of the treatment approach would seem to indicate.

In so far as the treatment requires at least two sessions per week over many months of treatment, it would appear to be an expensive form of long term psychotherapy. The fact is, however, that these patients typically require repeated hospitalizations, as well as presenting chronic failure at work, and needing medical attention to the specific symptomatic complications referred to before. Their need for expensive long term social support may lead, if unchecked, to secondary gain and social parasitism. Psychotherapy

geared to resolving severe personality disorders rather than simply providing an ongoing social support system may be less expensive than it would seem on the surface. Also, because this treatment aims at fundamental changes in the patient's personality as well as in his dominant symptoms, it has therapeutic aims unmatched by other treatments geared to the specific symptoms of severe personality disorders but not at modification

of the personality structure per se. Ongoing present research regarding the effectiveness, the process and outcome of this treatment is under way, and the manual currently being expanded should assist both researchers and clinicians in the field to become acquainted with a specific methodology geared to deal with one of our most challenging pathologies

in clinical practice.

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In a recent study (Clarkin et al., under review) we examined the efficacy of TFP. Twenty-three female patients diagnosed with DSM-IV borderline personality disorder began twice weekly TFP. Patients were assessed with diagnostic instruments, measures of suicidality, self-injurious behavior, symptomatology, social functioning and interpersonal relations, and measures of medical and psychiatric service utilization. Patients were reevaluated at 4, 8, and 12 months while participating in the study. Compared to the year prior to treatment, both the number of patients who made suicide attempts and the medical risk and seriousness of medical condition following attempts significantly decreased. Compared to the year prior, study patients during the treatment year had significantly fewer emergency room visits, psychiatric hospitalizations, and days of inpatient hospitalization and were less likely to be hospitalized. Additionally, over the course of the year of treatment, severity ratings of BPD criteria and symptoms significantly decreased, and reasons for living significantly increased. The dropout rate was 19.1%. This uncontrolled study is highly suggestive that extended outpatient TFP may result in considerable improvement in functioning in a broad range of areas. This structured and manualized psychodynamic treatment modified for borderline patients

shows promise for the ambulatory treatment of these patients. We have also examined treatment process in terms of factors related to early dropout (Yeomans, Gutfreund, Selzer, Clarkin, Hull, & Smith, 1994) and symptom

response (Hull, Clarkin, & Kakuma, 1993). We (Clarkin, Hull, Yeomans, Kakuma, & Cantor, 1994) have preliminary treatment data indicating that the different subgroups of Cluster B patients have a different response to treatment, giving some suggestion that these subgroups would have different trajectories across larger periods of time. Treatment course was found to be significantly associated with the level of antisocial

behavior reported at Time 1, with more antisocial patients having a worse trajectory of symptom change.

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A Response to Otto Kernberg

Aaron T. Beck

First I'd like to thank Dr. Kernberg for having given us an opportunity to listen to his very rich exposition of the ovucuvations approach to the borderline personality disorder. I imagine all of you who treat patients have had an opportunity to observe the kind of phenomena that Dr. Kernberg described. In our own work with borderlines we certainly

observed this too. I thought that perhaps one of the most helpful ways would be to talk about how we approach the borderlines from some with different vantage points using the cognate model as opposed to the motivational affect of dynamic model. One of the points we have in common is the notion of the three-legged stool. And in contrast to classical psychoanalytic approaches there's a large emphasis in both our

approaches in the here and now and I'd like to just mention an experience I had which illustrates much of the approach that we have theoretically and also could be used to illustrate the psychoanalytical approach. A

woman came in one time, I was going to see her in consultation, and she was sitting up when I came in and had kind of an angry expression on her face and I thought I could help to melt it. She'd been referred by her father who was one of the well known people in the community. I said to her, "Well I'm

happy to see you. I know your father very well and I'd be pleased to be part of the healthcare." And she said, "Is that why you're seeing me, because of my father?" And I said, "Well if that's going to be a problem we could refer you to somebody else." Then her expression changed, verbal/nonverbal, and she said, "Are you rejecting me?" I said, "Well, maybe it might be good if I could just ask you a few questions and try to get the background." She said, "Do you try to control everybody that comes in here." So each time there's the transference. Transference was made before she even came to see me. It was a pre-existing transfer. The splitting that Dr. Kernberg described was going back and forth. So finally I said, "Well, just tell me whatever you think might be helpful in my understanding." She said, "Well you're the doctor. Don't expect me to do everything." So here we see that the patient is projecting all sorts of things on to me and at the same time is experiencing

certain representations about herself as being vulnerable and at the same time compensating for it by trying to control and then being controlled by me. So one of the features that we have that we do go into with our cognitive approach to the borderlines is the transference. Also, we do try to relate. We try to utilize whatever information comes out in the transference to try to understand what's going on in the here and now. Now one aspect of our treatment of borderlines, which we don't utilize in the treatment study of the common variety of depressives, is the emphasis in early childhood

information. I think in some ways we dramatize it more than the psychodynamic approach because we actually try to get the patient to relive childhood trauma, to try to image what went on in the childhood and take up certain specific scenes that they recall. It may be a distorted recollection but it doesn't matter as far as their present reactions are concerned. This is the way they actually perceive things. We then would relate the childhood material, the childhood experiences to what's going on in the other two legs

of the stool, which is what's going on in terms of the transference and what's going on in their outside life.

The next point I want to make is that we actually conceptualize the treatment a bit differently. First of all, we emphasize trust. So while we do try to keep it neutral in terms of the patient's material, in terms of the affective relationship we can try to behave in such a way that the patient will not become more distrustful and hopefully will become less distrustful. We also make much of a point working at the surface even though there

may be unconscious factors that are driving what's coming out is we work on the surface distortion and try to modify them. But the basic approach which differs in some ways from the psychodynamic approach is that we go down to what we call the beliefs.

The major beliefs that we would get say early in the session are the things of

abandonment, things of rejection, which are two of the things that came out of that example he just gave, the things of badness and on loveability.

Now in all our work with patients there's one core concept that seems to

characterize the borderlines more than any other patients we see, more than the depressives or the other personality disorders . . . the I am bad. So there was one question that I would like to impress whether you do see I am bad or the sense of badness as a more prominent feature of the borderlines and perhaps fitting in with the scheme of it you present it on your first table which in terms of the pathology that perhaps the I am

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bad just encapsulates this whole sense of annihilationism and unlovability and so on. Then finally we activate the childhood trauma.

Another aspect of our work is the emphasis on homework assignments. We do give the patients work to do according to the cognitive model. And also, we try to build up the constructive beliefs and I think this must be part of your work because I'm kind of a second generation Meneghetti too and we always learn you've got to try to find some solid foundation with the patient and in one way or another encourage the working up of more constructive attitudes about themselves and about the outside world. In my experience, patients with borderline disorders who are given a questionnaire that we have on different dysfunctional beliefs will endorse practically all of the beliefs.

All the dysfunctional beliefs that are on the questionnaire get endorsed to a large degree much more so in the borderlines than in any of the other personality disorders. So the avoidant person might have the belief, "I can't stand having any unpleasant feeling." If there is a problem I try to avoid doing it. A dependent personality will endorse the notions, "If I don't have somebody to lean on I will die. Life isn't living if I don't have somebody to love." The psychopathic personality would say, "This is dog eat dog." The

paranoid personality is, "Nobody can be trusted." The borderline personality people endorse all of them. And indeed, in the course of therapy if one has unlimited time one can see each one of these dysfunctional beliefs coming up. We have a questionnaire called the personality dysfunctional questionnaire. These were the most strongly endorsed beliefs by the paranoid by the borderlines as opposed to all the other personality disorders. Being controlled or dominated by others is intolerable. I have to look out for myself. So that's something that we don't necessarily think of in terms of the borderline. But they do endorse this to a large degree. I have to depend on myself to see that things get done. Unpleasant feelings will escalate and get

out of control . . . can be nurturing and supportive and confident if he or she wants to be and I have to do things my own way.

Then finally, there's seven more of the most commonly endorsed beliefs, which also discriminate from the others. Being exposed as inferior inadequate would be intolerable. I can't cope as other people can. I cannot tolerate unpleasant feelings. I need to be in complete control of my emotions. And, I like to be attached to other people. I am fully responsible for myself and other. And the worst possible thing would be to be

abandoned. In the therapy itself, then, we try to get down to these beliefs that seem to be driving the various distortions that the patients have, which then account for their impulsivity, for their unstable relationships and for their suicidal impulses and then finally for their chronic dysphoria and ups and downs.

Contributions of Psychoanalysis

Psychoanalysis has made many contributions to the development of other psychotherapies, but in particular its understanding of attachment theory, transference, resistance and trauma have been studied by many other mental health professionals and incorporated in their own theories and practices.

These are some of "the still useful ideas that were originally packaged as "psychoanalysis." We really are in a much better position than Breuer and Freud, thanks to their efforts, to see what is going on in minds, bodies and lives.

- We know that children are compelled to avoid what they cannot tolerate of emotion.
- We know that growing up involves learning to handle immense and difficult emotions.
- We know that all of us have difficulties in a variety of ways that have to do with our earlier experiences.
- We know that reviewing and revisiting in and through relationships the remnants of the past embedded in the psyche and the soma in the present can provide opportunities for finding new ways of handling feelings, thoughts, and actions.

Peter Grant, Ph.D., Minneapolis Minnesota

Attachment Theory

The term "attachment" is used to describe the affective (feeling-based) bond that develops between an infant and a primary caregiver. The quality of attachment evolves over time as the infant interacts with his caregiver and is determined partly by the caregiver's state-of-mind toward the infant and his needs. [SEP:SEP]The father of attachment theory, John Bowlby, M.D., believed that attachment bonds between infants and caregivers have four defining features:

Proximity Maintenance: wanting to be physically close to the caregiver

Separation Distress: more widely known as "separation anxiety"

Safe Haven: retreating to the caregiver when the infant senses danger or feels anxious

Secure Base: exploration of the world knowing that the caregiver will protect the infant from danger.

The quality of a child's attachment during the formative years when her brain is developing at exponential rates informs the quality of her relationships throughout her life. It is important to note that attachment is not a one-way street. As the caregiver affects the child, the child also affects the caregiver. In a psychoanalytic treatment setting, the patient's journey towards self-discovery can mimic the attachment theory features presented by infants, with the analyst representing the caregiver. [SEP:SEP]"Attachment theory is critically important to understanding what happens to people, what their issues are, and why some people seem unreachable psychologically while others are accessible. With the goal of enabling attachment for the children of young mothers, we developed the Cradles to Classroom project, which provided childcare, healthcare, tutoring, and mentoring to every pregnant teen and teen mother in the Chicago School District. Attachment theory could be used as the scientific backbone of significant public policy advancements in providing maternal and child mental health support in the United States." [SEP:SEP]Carl C. Bell, M.D., President/C.E.O.

Community Mental Health Council and Professor of Psychiatry and Public Health, University of Illinois at Chicago.

Transference

Transference is a concept that refers to our natural tendency to respond to certain situations in unique, predetermined ways--predetermined by much earlier, formative experiences usually within the context of the primary attachment relationship. These patterns, deeply ingrained, arise sometimes unexpectedly and unhelpfully--in psychoanalysis, we would say that old reactions constitute the core of a person's problem, and that he or she needs to understand them well in order to be able to make more useful choices. Transference is what is transferred to new situations from previous situations.

As a result, a person's relationship to lovers and friends, as well as any other relationship, including his psychoanalyst, includes elements from his or her earliest relationships. Freud coined the word "transference" to refer to this ubiquitous psychological phenomenon, and it remains one of the most powerful explanatory tools in psychoanalysis today—both in the clinical setting and when psychoanalysts use their theory to explain human behavior.

Transference describes the tendency for a person to base some of her perceptions and expectations in present day relationships on his or her earlier attachments, especially to parents, siblings, and significant others. Because of transference, we do not see others entirely objectively but rather "transfer" onto them qualities of other important figures our earlier life. Thus transference leads to distortions in interpersonal relationships, as well as nuances of intensity and fantasy.

The psychoanalytic treatment setting is designed to magnify transference phenomena so that they can be examined and untangled from present day relationships. In a sense, psychoanalyst and patient create a relationship where all the patient's transference experiences are brought into the psychoanalytic setting and can be understood. These experiences can range from a fear of abandonment to anger at not being given to fear of being smothered and feelings of dependency or excessive idealization, and on and on.

One common type of transference is the idealizing transference. We have the tendency to look towards doctors, priests, rabbis, and politicians in a particular way—we elevate them but expect more of them than mere humans. Psychoanalysts have a theory to explain why we become so enraged when admired figures let us down.

The concept of transference has become as ubiquitous in our culture as it is in our psyches. Often, references to transference phenomenon don't acknowledge their foundation in psychoanalysis. But this explanatory concept is constantly in use. For example, the solution of a murder mystery a detective story turns on the police officer's realization that the murderer has a "mother complex" and he both loves and hates his murder victims, as he did his mentally unstable mother. Pure Freud.

In a television series (Madmen, season 3), the female lead is romantically drawn to a significantly older man just after her father dies. She sees him as extraordinarily competent and steady.

Many types of modern day therapy, coaching and self help use transference in a manipulative way, though not necessarily negatively. Instead of self understanding, the slow and painstaking goal of

psychoanalysis, many short term treatments achieve powerful reactions in clients by making use of the therapist or leader as a powerful, charismatic " transference" figure—a guru who readily accepts the elevation transference provides, and uses it to prescribe or influence behavior. Essentially, the therapist/coach/leader accepts the transference as omnipotent parent and uses this power to tell the client what to do. Often the results obtained are short lived, unfortunately, and here psychoanalysis can be helpful.

Resistance

Resistance is one of the two cornerstones of psychoanalysis. (See also transference.) As uncomfortable thoughts and feelings begin to get close to the surface--that is, become conscious--a patient will automatically resist the self-exploration that would bring them fully into the open, because of the discomfort associated with these powerful emotional states that are not registered as memories, but experienced as fully contemporary--transferences! The patient is thus experiencing life at too great an intensity because he or she is burdened by transferences or painful emotions derived from another source, and must use various defenses (resistances) to avoid their full emotional intensity.

These resistances can take the form of suddenly changing the topic, falling into silence, or trying to discontinue the treatment altogether. To the analyst, such behaviors would signal the possibility that a patient is unconsciously trying to avoid threatening thoughts and feelings, and the analyst would then encourage the patient to consider what these thoughts and feelings might be and how they continue to exert an important influence on the patient's psychological life.

As the analysis progresses, patients may begin to feel less threatened and more capable of facing the painful things that first led them to analysis. In other words, they may begin to overcome their resistance.

Psychoanalysts consider resistance to be one of their most powerful tools, as it acts like a metal detector, signaling the presence of buried material.

Examples of resistance can be seen in the culture at large. For example, as a society, we can turn our gaze away from painful truths of our collective past and present. In post apartheid South Africa, the Truth and Reconciliation program can be seen as a nation-wide commitment to avoid the burying of painful material that leads to blindness and resistance.

Trauma

Trauma is a severe shock to the system. Sometimes the system that's shocked is physical; the trauma is a bodily injury. Sometimes the system is psychical; the trauma is a deep emotional blow or wound (which itself might be connected to a physical trauma). It's the aftereffects of the psychical trauma that psychoanalysis can attempt to counteract.

While many emotional wounds take a while to resolve, a psychic trauma may continue to linger. When the stimulus is powerful enough--a death, for instance, or an accident--the psyche isn't able to respond sufficiently through regular emotional channels such as mourning or anger.

Often this lack of resolution can foster a repetition compulsion--a chronic re-visiting of the trauma through rumination or dreams, or an impulse to place oneself in other traumatic situations.

Psychoanalysis can help the victim to develop emotional and behavioral strategies to deal with the trauma.

Fortunately, the need for trauma survivors to have treatment is now well understood in the broader mental health community. Certain medications are helpful in the treatment of trauma, but there should always be a psychological component to the treatment, and it must be understood that treatment can be needed years after the trauma is experienced. Psychoanalysts did much of the early work in treating trauma, from shell shock of WWI, War Neurosis of WWII, Post Vietnam Syndrome of the Viet Nam war, and now Post Traumatic Stress Disorder (PTSD). Treatment of PTSD still contains elements that harken back to psychoanalysis—trauma patients need a witness to their pain, who helps them, bit by bit, incorporate the traumatic experience with the rest of the story of their lives in some way that can make sense. Facing unbearable feelings with another human being, and supporting and employing the ego—the part of the mind responsible for decision making, understanding cause and effect, and discrimination—all these techniques owe their roots to psychoanalysis.

History of American Psychoanalytic Theory

Psychoanalysis became established in America between World War I and World War II, when Americans traveled to Europe to take advantage of psychoanalytic training opportunities there. The single major therapeutic perspective that was transplanted to the United States was ego psychology, based centrally on Sigmund Freud's *The Ego and the Id* (1923) and *The Problem of Anxiety* (1936), followed by Anna Freud's *Ego and the Mechanisms of Defense* (1936) and Heinz Hartmann's *Psychoanalysis and the Problem of Adaptation* (1939). This perspective of psychoanalysis was dominant in America for approximately a 50-year span until the 1970s. Meanwhile, in Europe, various theoretical approaches had been developed.

In 1971, Heinz Kohut's book, *The Psychology of the Self*, inaugurated a new theoretical perspective in American psychoanalysis. Soon after, Margaret Mahler's developmental approach was espoused by some, and a growing diversification in therapeutic approaches in the American schools of psychoanalysis began.

Current Psychoanalytic Treatment Approaches

Today, the ego psychology that was dominant in American psychoanalytic thought for so many years has been significantly modified and is also currently strongly influenced by the developing relational point of view. The diverse schools of therapeutic approach currently operative in America include influences from British object relationists, "modern Freudians", the theories of Klein and Bion, self-psychology, the Lacanians, and more. Truly, a kaleidoscope of approaches is now available at psychoanalytic institutions in the United States. Many psychoanalysts believe that the human experience can be best accounted for by an integration of these perspectives.

Whatever theoretical perspective a psychoanalysis employs, the fundamentals of psychoanalysis are always present—an understanding of transference, an interest in the unconscious, and the centrality of the psychoanalyst-patient relationship in the healing process.

http://www.apsa.org/About_Psychoanalysis/Contributions_of_Psychoanalysis.aspx

Converting a Freudian analysis into a Jungian one: obsession, addiction, and an answer from Job.

[Kradin R.](#)

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<http://www.borderlinedisorders.com/transference-focused-psychotherapy.php>

Transference Focused Psychotherapy for Borderline Patients

<http://psybc.com/pdfs/library/KERNBERG.pdf>

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Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: randomised controlled trial.

PAPERS

Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: randomised controlled trial

[Int J Psychoanal.](#) 2014 Aug;95(4):695-717. doi: 10.1111/1745-8315.12208. Epub 2014 Jun 10.

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[Wille R.](#)

[J Anal Psychol.](#) 2014 Jun;59(3):391-409. doi: 10.1111/1468-5922.12088.

Learning from the patient: the East, synchronicity and transference in the history of an unknown case of C.G. Jung.

[de Moura V.](#)

[J Anal Psychol.](#) 2014 Jun;59(3):391-409. doi: 10.1111/1468-5922.12088.

Learning from the patient: the East, synchronicity and transference in the history of an unknown case of C.G. Jung.

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[Int J Psychoanal.](#) 2008 Jun;89(3):601-20. doi: 10.1111/j.1745-8315.2008.00046.x.

Transference focused psychotherapy: overview and update.

[Kernberg OF](#)¹, [Yeomans FE](#), [Clarkin JF](#), [Levy KN](#).

TREATMENT CONDITIONS AND THERAPISTS

Both treatments were offered in 50-minute sessions twice a week. Treatment protocols addressed the theoretical model, treatment frame, different phases, and use of strategies and techniques.[13,14,16,17](#) Central to SFT is the assumption of 4 schema modes specific to BPD. Schema modes are sets of schemas expressed in pervasive patterns of thinking, feeling, and behaving. The distinguished modes in BPD are detached protector, punitive parent, abandoned/abused child, and angry/impulsive child. In addition, some presence of the healthy adult is assumed. Change is achieved through a range of behavioral, cognitive, and experiential techniques that focus on (1) the therapeutic relationship, (2) daily life outside therapy (also through homework assignments), and (3) past (traumatic) experiences. Recovery in SFT is achieved when dysfunctional schemas no longer control or rule the patient's life. Central to TFP is a negotiated treatment contract between patient and therapist, being the treatment frame. Change is achieved through analyzing and interpreting the transference relationship, focusing on the here-and-now context. Prominent techniques are exploration, confrontation, and interpretation. Recovery in TFP is reached when good and bad representations of self (and of others) are integrated and when fixed primitive internalized object relations are resolved.